

# CREEPING AND LEAPING FROM PAYMENT FOR VOLUME TO PAYMENT FOR VALUE

An Update on Behavioral  
Healthcare Payment Reform



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## SETTING THE STAGE...

*Creeping and Leaping* has been written for those who are curious about how the near future of behavioral health delivery and payment will differ from the present or past.

As you read this paper, keep in mind that no one can predict exactly how the future will unfold or how behavioral health delivery models and payment approaches will vary across our large and diverse nation. Put your thinking cap on and make your best effort to translate these ideas for your local environment. Consider the following:

- Who might be your payors in two and five years and what are they currently thinking about payment reform?
- What direction is the integration of behavioral health and primary care taking in your state and community? Will you be able to succeed in partnering with primary care to provide behavioral health services in that setting? If so, pay careful attention to how primary care payment models are changing.

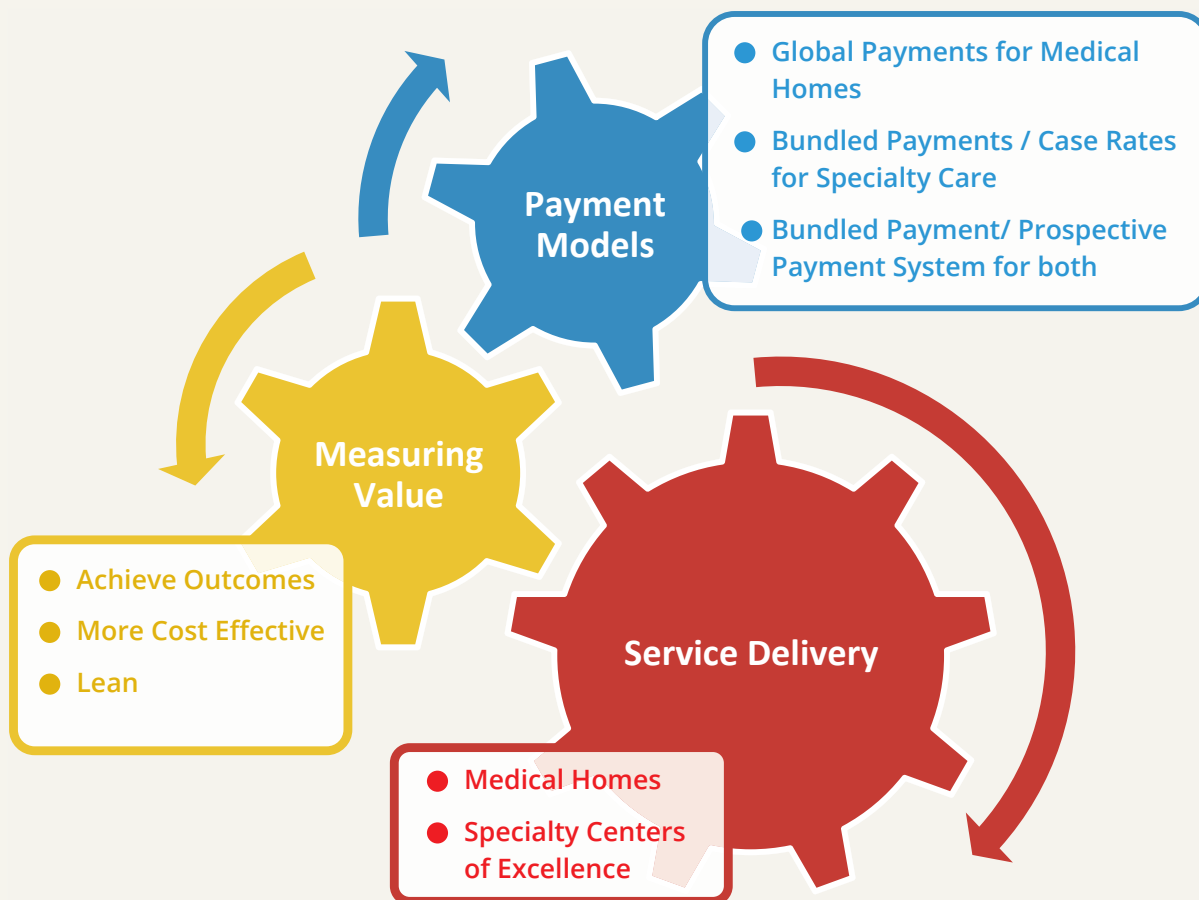
## OVERVIEW

The near future is quite exciting for both consumers and providers of healthcare and behavioral healthcare because we are *finally* increasing the pace of aligning how we pay for services with the outcomes we are attempting to achieve — better health, better care, and better costs.

Payment models are moving away from paying for volume to paying for value, and understanding the new payment models requires insight into how behavioral health service delivery models are evolving and how *value* is being defined and measured in this new ecosystem.

Healthcare payment reform will likely bring three predominant payment models to behavioral health: **Global Payments** for providers working in medical homes; **Bundled Payments** through **Prospective Payment Systems** for providers that achieve the recently created designation of Certified Community Behavioral Health Clinics; and **Case Rates** for providers working in specialty behavioral health clinics.

This paper provides an overview of the service delivery and payment models that are emerging for behavioral health providers as health reform continues to unfold. A companion paper, *Case Rate Toolkit: Preparing for Bundled Payments, Case Rates and the Triple Aim* provides additional detail on how to prepare for these models.



## THE FUTURE OF BEHAVIORAL HEALTH SERVICE DELIVERY

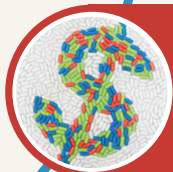
There is a growing awareness of the high **prevalence** of behavioral health disorders, the high **comorbidity** of behavioral health disorders and chronic health conditions, and the high healthcare **costs** for Americans with behavioral health disorders.



In 2011, more than 41 million U.S. adults (18 percent) had any mental illness, and nearly 20 million (8 percent) had a substance use disorder.



In 2002, 49% of all Medicaid beneficiaries with disabilities in the United States had a psychiatric diagnosis and these individuals were in three of the top five most expensive comorbidity groups.



Behavioral health disorders were one of the five most costly conditions in the United States in 2006, with expenditures at \$57.5 billion.

This awareness affirms two roles for the nation's behavioral health providers in the new health delivery ecosystem.

1. **Behavioral Health Inside Medical Homes**, becoming deeply embedded as part of primary care teams providing prevention and early intervention services, addressing *health behaviors* as well as treating *behavioral disorders*.
2. **Behavioral Health Specialty Centers of Excellence** that partner with medical homes, providing high value, whole health-oriented, specialty care to individuals with complex behavioral health conditions.<sup>1</sup>

Through these two provider roles, more people with behavioral health disorders are being engaged in whole person care and effectively treated. Studies from Alaska, California, Colorado, Minnesota, Missouri, Utah, and Washington, and other states demonstrate that implementing integrated care designs is improving outcomes and reducing costs.<sup>2</sup> Increasing integration combined with health reform related coverage expansion is generating greater demand for properly trained behavioral health professionals and paraprofessionals. There is also a rapidly expanding expectation that the organizations employing these individuals must perform as high-value health delivery organizations.

1. More information on the BHCOE effort can be found at:

[www.thenationalcouncil.org](http://www.thenationalcouncil.org) or <https://www.thenationalcouncil.org/conference-365>.

2. Mauer and Jarvis. The Business Case for Bidirectional Integrated Care. CIMH. June 2010.

Parks, Swinfard, Stuve. Mental Health Community Case Management and Its Effect on Healthcare Expenditures. *Psychiatric Annals* 40:8. August 2010.



It will be essential for behavioral health providers to develop and present a “business case” to purchasers, payors, and other healthcare providers that demonstrate their value in the areas of quality, costs and outcomes.

As medical homes expand their footprint, supported by payment reform, there is emerging evidence that clinical staffs are becoming more thoughtful about specialist referrals. For example, imagine being a clinician in a medical home, treating a patient who has a serious heart condition or a major mental illness beyond the scope of what you can treat at your clinic. Not only do you want to do right for your patient, but part of your pay is based on performance measures related to the health of your patients.

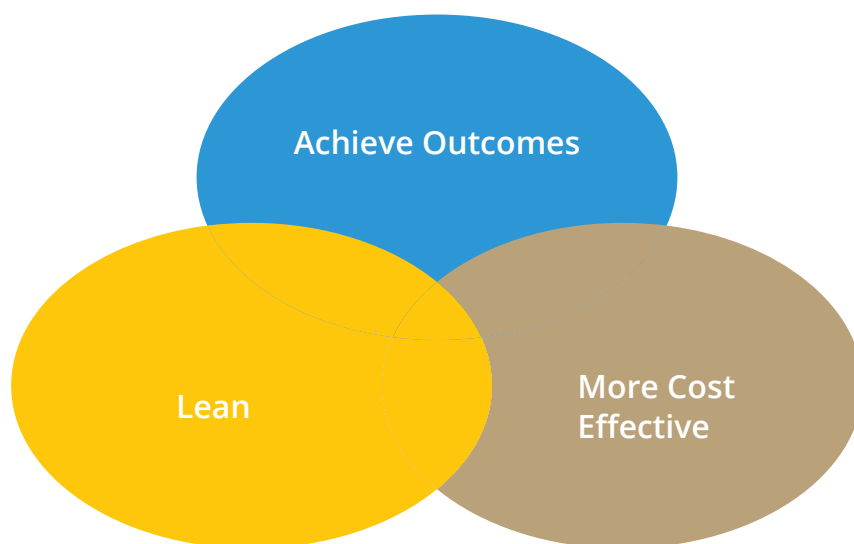
In this new performance-based environment, you can no longer afford to make referrals to specialty providers lacking cost and outcomes data or that you know to be poor performers with high error rates, high costs and poor outcomes. Instead, you must become meticulous about building relationships with high performing specialists to support the whole health of your patients. In other words, *you are looking for specialty centers of excellence*. This will be true for cardiologists, endocrinologists, otolaryngologists, behavioral health specialists, and all other specialty providers.

## MEASURING THE VALUE OF BEHAVIORAL HEALTH IN THE NEW HEALTH DELIVERY ECOSYSTEM

Healthcare researchers are moving toward a definition of value that has three characteristics.

1. The services are effective in achieving individual **outcomes** or system-wide outcomes;
2. The services are more **cost-effective** than alternatives that may have been selected;
3. The service are **lean**, meaning that waste (excess costs) have been removed through process improvement activities.

### THREE CHARACTERISTICS OF VALUE



**Outcomes Based Care:** The first characteristic includes measuring outcomes for every patient. Ideally providers — including behavioral health providers — will use a treat to target, team-based care approach to achieve clear and measurable successes at the patient level. The patient, with support of their care team, identifies in the assessment process behavioral health treatment targets (identified needs) as well as personal goals. Then, for each behavioral health treatment target, one behavioral health goal is developed and associated with one or more personal goals. Outcome tools relevant to the clinical goals are used to collect baseline information and measurable targets are set. Professional and self-care plans are developed, drawing from scientific evidence about the patient's background, conditions and goals. Frequent measurement is made and, if a patient isn't reaching their targets, the care plan and self-care plan are changed. Patient-level outcome data are collected in a central repository, evaluated on a regular basis and used to continuously improve care.

This model has been implemented in Washington State by a local health plan in conjunction with the University of Washington AIMS Center. Two notable aspects of the project have been the importance of a patient registry to routinely collect, examine and use data to support clinical decision making; and a pay for performance bonus layer that kicks in when an individual's targets are reached or if the care plan is changed because targets aren't being reached.

**Cost-Effective Care:** The second characteristic necessitates thinking about the cost-effectiveness of the treatment approaches. Providers must ask, "Is my care making a difference and are the clinical guidelines/best practices I'm using more cost effective than other options that could also obtain similar results?" This is new for many behavioral health organizations. It's not enough to deliver a successful intervention. If a center across town achieves the same outcomes for similar patients using different approaches that require less duration and/or intensity – and people start to figure this out – you will not be seen as the provider of choice.

**Lean:** The third characteristic requires that a defined approach to quality improvement, generally lean, is being used throughout the organization. This approach uses rapid cycle improvement methods to remove waste (excess costs) from the work processes, which often results in less cumbersome, more customer friendly workflows for patients.

In short, organizations that provide high value services are able to provide higher quality care at lower cost than their peers.

Measuring the value of behavioral health also parallels the two roles of behavioral health providers in the new health delivery ecosystem.

## Behavioral Health inside Medical Homes

Behavioral health providers partnering with medical homes will need to understand and support the performance measures by which these types of organizations are being measured. A sampling of those standards is included to the right.

Behavioral health providers must take the time to understand which of these standards and measures are important to their primary care partners and then become competent in helping patients manage the related conditions. For example, Oregon's PCPCH Adult Core Quality Measures include:

- Adult Weight Screening and Follow-Up
- Medical Assistance with Smoking and Tobacco Use Cessation

- Comprehensive Diabetes Care: HbA1c Control
- Controlling High Blood Pressure

We also now recognize that effectively assessing and treating behavioral health disorders is in the critical path of managing these conditions. An individual with depression and diabetes is not going to be able to self-manage their diabetes until their depression is under control. Substitute any behavioral health and serious health condition and the result is the same; anxiety disorder and heart disease, bipolar disorder and pulmonary disease, alcohol abuse and obesity.

Successfully managing each of the conditions noted above contains a major health behavior component and it will be incumbent on the behavioral health providers on the primary care-based care team to support behavior change and adoption of healthy lifestyles.

Overall, the key question for behavioral health clinicians embedded in medical homes is: Are we helping the clinics bend the cost curve through improved outcomes at the patient level and improved health at the population level, based on the metrics to which the medical homes are being held?

#### PERFORMANCE STANDARDS FOR MEDICAL HOMES



- National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) recognition standards,
- Joint Commission PCMH certification standards,
- Federally Qualified Health Center (FQHC) standards,
- State-specific standards (e.g. Oregon Patient Centered Primary Care Home [PCPCH])

### Measuring Value in Behavioral Health Specialty Centers of Excellence

In addition to focusing on the three characteristics of value, specialty behavioral health will need to carefully align with the performance measures to which their payors are being held. This includes NCQA HEDIS measures for health plans, NCQA accreditation measures for Managed Behavioral Health Organizations (MBHOs), and state specific performance measures for health plans and carve-out managed behavioral health organizations.

Using another Oregon example, Coordinated Care Organizations (CCOs), which are integrated medical, mental health and addictions risk bearing entities for the Medicaid system, have 17 performance measures tied to significant incentive pools. At least seven of these measures can be affected by the performance of specialty behavioral health providers:

- Follow-up after hospitalization for mental illness
- Screening for clinical depression and follow-up plan
- Mental and physical health assessment within 60 days for children in DHS custody (child welfare)
- Outpatient hospital and emergency department utilization
- Controlling high blood pressure\*
- Diabetes: HbA1c Poor Control\*
- Access to Care: Getting Care Quickly

(\*NOTE: It is quickly becoming the expectation that specialty behavioral health must ensure that patients taking psychotropic medications that affect blood pressure and blood sugar levels must participate in managing those conditions.)

The key question for specialty behavioral health is: Are we known for and actually delivering great outcomes at the patient level and improved health at the population level?



## THE FUTURE OF BEHAVIORAL HEALTH PAYMENT MODELS

There is overwhelming evidence that the fee for service payment model is the poster child of paying for volume instead of value. We also know that older grant-in-aid models do not fit into a modern payment structure because of the disconnect between either volume or value.

So, what's next for behavioral health?

The three-part answer aligns with the two settings in which behavioral health will be provided.

### Global Payments for Medical Homes

There is an emerging consensus that the main early payment reform model for medical homes is not working. Under this three-layer payment model, the payor continues to reimburse fee-for-service for discrete procedures; adds a care management per member per month layer for services that don't lend themselves to fee-for-service; and finishes with a shared savings layer that rewards the clinic with a portion of the total healthcare expenditures saved for the patient population if baseline quality measures are met. In most cases, 90% to 95% of the payment in this model remains fee-for-service, and "payment for volume" incentives remain in place.

The newer model – Global Payments – moves away from fee-for-service and is gaining traction. Under this method, medical homes work with payors to complete a zero-based budgeting exercise that answers the following questions.

- Based on the complexity and severity of my patient population, how many clinicians of what disciplines are needed to support a team-based care model where the clinic becomes a health and wellness center for those without complex medical conditions and an emergency room and hospital prevention organization for my patients with complex and multiple comorbid conditions?
- What infrastructure is needed (technology, facilities, support staff, etc.) to support these high performing teams?
- What is the price tag for creating this clinic and how does it translate into a per-patient-per-month (PPPM) rate?
- What is a standardized PPPM rate for all clinics that can then be risk adjusted for the severity and complexity of the patients within a given medical home?
- What are the key performance indicators that will support identification that the services being delivered are "lean"?
- What are the performance metrics that need to be in place to measure whether the clinic is meeting the stated aims and is providing lean services?

Note that this budgeting exercise is for medical home costs only. Risk for inpatient and specialty care is not built into the formula.

The Global Payment then becomes a monthly payment from each payor to each clinic based on the number of patients enrolled multiplied by the per-patient-per-month rate. A number of these projects are also adding a shared savings layer that provide a bonus to the clinics if total healthcare expenditures are reduced more than the extra money paid to the medical home.

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3. Harold Miller. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Center for Healthcare Quality & Payment Reform. 2012.

Where does behavioral health fit in? The behavioral health staff and related infrastructure costs simply become a line item in the global budget of the medical home. If behavioral health is being provided on a contract through a behavioral health provider organization, the cost of that contract is built into the global budget.

There's only one catch.

By definition, extra staffing and extra infrastructure to achieve the promise of the medical home substantially increases the budget paid through a Global Payment. If a medical home is not able to deliver on outcomes and save enough money through a reduction in emergency room, inpatient, and diagnostic imaging costs, the payors for that medical home will likely move the clinic back to fee for service and take their Global Payment business elsewhere. Therefore, the focus on an ability to appropriately measure and deliver "lean" services will be a core element.

## Bundled Payments in Specialty Behavioral Health Settings

Outside of the medical home, it is likely that care will be paid through bundled payments or remain fee-for-service, but with much tighter management. This includes inpatient care and specialty care including specialty behavioral health.

A Bundled Payment is a predetermined amount paid to a provider organization to cover the cost of all of a given set of services. This can be structured in different forms, including a **Prospective Payment System** (PPS) which covers a defined scope of services or, even more precisely, in the form of a **Case Rate** which covers the average cost of all services for a given defined episode of care for an individual over an agreed-upon time period.

### MEDICAL HOMES



Global Payments

### SPECIALTY BEHAVIORAL HEALTH



Bundled Payments/Case Rates

## PROSPECTIVE PAYMENT SYSTEM

The first of these forms of bundled payments, PPS, currently exists for providers such as Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Prospective Payments for FQHCs and RHCs began in 2001 as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Under this Act, state Medicaid authorities were required to make per-visit bundled payments "equal to the reasonable cost of such services documented for a baseline period, with certain adjustments, or to use an alternative payment methodology to pay for FQHC and RHC services." FQHC/RHC PPS is a blend of a cost-based reimbursement system and fee for service, containing the following characteristics.

4. CMS State Health Official #10-004. Prospective Payment System for FQHCs and RHCs. February 4, 2010.

- PPS pays a single per-visit rate that bundles all of the care provided during that visit, regardless of the type of visit, who provided the service, or how long the service took.
- PPS is based on the average cost of all allowed services in the bundle provided at a given FQHC or RHC.
- PPS supports comprehensive FQHC/RHC services including primary care, dental, mental health, pharmacy, immunizations, chronic care management, and more.
- PPS rates are determined separately for each individual FQHC or RHC, adjusted each year by the Medicare Economic Index for primary care. Centers are also able to adjust their rate if they have a change in their scope of services.
- The term “Prospective” is used because the per-visit rate is pre-negotiated and there is no after-the-fact settlement to actual costs.

FQHC/RHC PPS was designed to ensure that health centers receive fair payment for Medicaid and CHIP (Children’s Health Insurance Program) patients, especially in states where Medicaid/CHIP rates are set at unreasonably low levels. As a federal requirement, states have to use a PPS model or approved alternative for FQHCs and RHCs if they want to participate in the Medicaid and CHIP programs. This has resulted in FQHCs and RHCs being one of the few areas of the U.S. primary care system where clinics are adequately funded to provide comprehensive, high quality care. This in turn has allowed health centers to be early adopters of health home models. It has been reported that FQHCs and RHCs save the health care system \$24 billion annually in reduced emergency, hospital, and specialty care costs.<sup>5</sup>

In March 2014, Congress passed and President Obama signed into law the Excellence in Mental Health Act, the most sweeping piece of federal mental health legislation in two generations. The law, in part, calls for the creation of Certified Community Behavioral Health Clinics (CCBHCs) as entities designed to serve individuals with serious mental illnesses and substance use disorders. CCBHCs will provide intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services.

CCBHCs will begin as an eight state demonstration program that will roll out by September 2017. Among other requirements, participating states will be required to develop a Prospective Payment System.

Although the Centers for Medicare & Medicaid Services (CMS) will not issue guidance for the establishment of a PPS for CCBHCs until September 2015, we anticipate that the PPS will be similar to the existing system for FQHCs and RHCs – a comprehensive, per-visit bundled payment, based on an initial cost study, adjusted annually for inflation.

## CASE RATES

Case Rates are a form of bundled payment that covers the cost of a “case.” Let’s make this definition a bit longer: A Case Rate represents a predetermined amount of money paid to a provider organization to cover the average costs of all services needed to achieve a successful outcome for a given defined episode of care for an individual over an agreed upon time period.

5. Ku et al. Using Primary Care to Bend the Curve: The Effect of National Health Reform on Health Center Expansions. Geiger Gibson/RCHN Community Health Foundation. June 30 2010. Policy Research Brief No. 19.

**Example:** We will pay you \$3,500 for providing six months of community-based, recovery-oriented services for an adult mental health consumer who requires LOCUS Level 3 services. Your part of the bargain is to work with the consumer to develop a recovery-oriented professional care plan and self-care plan, identify at least one clinical goal and one personal goal, use a validated measurement tool to track progress on the clinical goal, work toward the agreed upon outcomes, change the care plan as needed, and get high marks on your customer satisfaction survey. Simple, right?

#### CASE RATES:

a predetermined amount paid to a provider organization to cover the cost of all of the services required for a given episode of care.

### Case Rates are Important for Two Main Reasons

- 1) Case Rates provide much greater flexibility to the provider and consumer regarding who provides services, what can be provided, and where services can be provided — the consumer and provider decide and can be more agile about what's needed.
- 2) Case Rates have a two-part value equation built into the process. First, if a care team selects a package of services for a consumer that is more cost-effective than other alternatives for achieving the desired outcome, the episode's actual cost may be lower than the case rate payment, allowing the provider to earn what some describe as a 'value bonus'. The second 'value lever' is to remove waste (excess cost) through lean process improvement activities, achieving a lower unit cost than what was built into the case rate.

This agility and value is possible because Case Rate amounts are generally developed and set after determining an average rate per unit and the average number of units of service required to achieve a positive outcome. If you can achieve good outcomes with fewer units at a lower cost, you earn a value bonus.

Note that Case Rates can also result in a reduction in administrative costs, when compared to fee for service. Although payors will require the submission of encounters under a Case Rate system, providers do not have to manage the intricacies of primary and secondary billing cycles for services provided to enrollees of a payor that pays Case Rates.

### What Case Rates are NOT

Case Rates are NOT a fixed budget for an individual consumer. Case Rates are an AVERAGE payment for all of the consumers to be served at a given level of care. By definition, some individuals will require MORE care at a given Case Rate Level and some will require LESS care in order to achieve the intended outcomes. Case Rates are meant to provide flexibility to the provider and consumer, not lock them into a rigid box.

King County in Washington State has had mental health case rates since 1994, and is the longest running mental health case rate system in the country. Mental health case rates have also been used in Indiana, Maryland, Ohio, Oregon, Wisconsin, and recently rolled out as a funding model for community mental health organization health homes in Rhode Island.

## WHAT'S NEXT?

As purchasers and payors of behavioral health services increase their focus on payment reform, it will be important for providers of behavioral health services to focus their “business case” preparations from both an internal and external capacity standpoint. These preparations are shaping up to be the key components of survival for behavioral health providers, centered on quality, costs and outcomes. A companion paper, *Case Rate Toolkit: Preparing for Bundled Payments, Case Rates and the Triple Aim* provides additional detail on how to prepare for these emerging payment models.

**Internal Preparation:** Behavioral Health providers will need to assess their readiness to become a center of excellence or to attain the newly enacted CCBHC designation. This readiness will be marked by a center being seen as a great place to get care and a great place to work. To achieve these “excellence” goals, the staff and management team will need to look at how their organization can best measure, showcase, and continuously improve quality, cost, and outcome performance. Supporting value-based service delivery will depend on these three primary areas of transformational change, with associated key characteristics, as outlined below. Further, centers will need to have the ability to share outcome and other key trend data graphically with patients, staff and payers.

### 1. Quality of Care Service Delivery Indicators:

- Same day access to treatment and open access for medical services
- Collaborative documentation process
- Levels of Care/Benefit Designs to ensure a consistent level of service is provided for all patients/populations assessed to have a specific level of need
- Clinically integrated “treat to target”/episode of care, brief therapy model
- Use of specific Evidence Based Practices

### 2. Cost of Services/Value Indicators:

- Knowledge of cost and revenue per CPT/ HCPC code by staff type (i.e., MDs/APRNs, LCSWs, etc.)
- A functioning utilization management plan in place to monitor the level of services being provided in line with the level of care/benefit design criteria
- Ability to link the identified outcomes to the cost of services needed to produce the identified outcomes

### 3. Outcomes Achieved Indicators:

- Moving beyond “having outcomes” to being able to collect, measure and compare how patients are benefiting from services being delivered – how the patient, staff, and payer know that the patient is getting “better”
- Looking beyond signs and symptoms of illness to how the remaining level of symptoms are affecting the patient’s ability to function in daily living activities
- Implementing an academic, valid, and inter-rater reliable functional assessment tool to focus individualized treatment plans

Depending on your staff and leadership's evaluation of which of the above indicators present, a current challenge for your behavioral health center, you can then strategize how best to use the companion *Case Rate Toolkit* to support transformational change planning.

**External Preparation:** Behavioral health providers need to work collaboratively within regions or their state to proactively help answer a set of key public policy questions that are being tackled by purchasers and payors.

- Does our state apply to be part of the CCBHC demonstration program? If so, what preparations are needed to successfully compete?
- What Level of Care system and criteria will be used in my community or state to define behavioral health episodes of care?
- What internal work have we done and what external research is available to help determine the utilization and cost of typical care for behavioral health episodes at different levels?
- What quality of care, cost of services and outcome indicators will be needed to develop a “business case” demonstrating their capacity to be a helpful partner/service delivery provider and how will their business case be presented to other healthcare providers in their market area?

## CONCLUSION

The healthcare field is learning how to operationalize the definition of value in healthcare and behavioral healthcare. It is likely that healthcare payment reform will bring three predominant payment models to behavioral health: Global Payments, for providers working in medical homes, and Bundled Payments, for providers working in specialty behavioral health clinics, in the form of per visit Prospective Payments and episode of care-based Case Rates. We anticipate that most community behavioral health providers will need to manage all three payment models simultaneously. The behavioral health providers that ultimately survive and thrive are those that will have brought focused attention to the internal and external factors that demonstrate their critical value.